

# AUTHORIZATION TO START, STOP OR CHANGE AN ALLOTMENT

## PRIVACY ACT STATEMENT

**AUTHORITY:** 37 U.S.C. Section 701, E.O. 9397.

**PRINCIPAL PURPOSE:** To permit starts, changes, or stops to allotments. To maintain a record of allotments and ensure starts, changes, and stops are in keeping with member's desires.

**ROUTINE USES:** In addition to those disclosures generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, these records of information contained therein may specifically be disclosed outside the DoD as a routine use to the Federal Reserve banks to distribute payments made through the direct deposit system to financial organizations or their processing agents authorized by individuals to receive and deposit payments in their accounts. It may also be disclosed to the Treasury Department, Internal Revenue Service, Social Security Administration, Department of Veterans Affairs, Federal, state and local agencies for civil or criminal law enforcement. In addition it can be released for any of the blanket routine uses published at the beginning of the DFAS compilation of system of record notices.

**DISCLOSURE:** Voluntary; however, failure to provide the requested information as well as the Social Security number may result in the member not being able to start, change, or stop allotments.

## TO BE COMPLETED BY ALLOTTER

<b>1. BRANCH OF SERVICE</b> ( <i>X one</i> ) <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY		<b>2. NAME OF ALLOTTER</b> ( <i>Last, First, Middle Initial</i> ) (Print or type)		<b>3. SSN</b>		<b>4. PAY GRADE</b>	
<b>5. ADDRESS OF ALLOTTER</b> ( <i>Street or Box Number, City, State, ZIP Code</i> )				<b>6. DAYTIME TELEPHONE NUMBER</b> ( <i>Include Area Code</i> )		<b>7. EFFECTIVE DATE</b> ( <i>YYYYMM</i> )	
<b>9. NAME OF ALLOTTEE</b> ( <i>First, Middle Initial, Last</i> )				<b>10. ALLOTMENT ACTION</b> ( <i>X one</i> ) <input type="checkbox"/> START <input type="checkbox"/> STOP <input type="checkbox"/> CHANGE		<b>8. MONTHLY AMOUNT OF ALLOTMENT</b> \$	
<b>12. CREDIT LINE</b> ( <i>If applicable</i> )				<b>13. ALLOTMENT CLASS AUTHORIZED</b> ( <i>X one</i> ) <input type="checkbox"/> C - CHARITY/CFC <input type="checkbox"/> D - DISCRETIONARY ALLOTMENTS ( <i>Includes dependent support, payment to financial institution, insurance, repayment of home loan, rent, etc. (Notes 1 and 2)</i> ) <input type="checkbox"/> F - CHARITY - EMERGENCY/ASSISTANCE FUND CONTRIBUTION <input type="checkbox"/> L - REPAYMENT OF LOAN TO SERVICE ORGANIZATION ( <i>Red Cross, Relief Society, etc. - Navy and Marine Corps only</i> ) <input type="checkbox"/> N - NSLI OR USGLI INSURANCE PREMIUM <input type="checkbox"/> T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/EMPLOYMENT TAXES <input type="checkbox"/> - OTHER ( <i>Specify</i> )			
<b>14. ALLOTTEE'S MAILING ADDRESS</b> ( <i>Street or Box Number, City, State, ZIP Code</i> )							
<b>15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS</b> ( <i>Province, Country</i> )							
<b>16. REMARKS</b>							
<b>17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER</b>				<b>18. ACCOUNT NUMBER/POLICY NUMBER</b>		<input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
				<b>19. TOTAL CLASS L AMOUNT</b> \$		<b>20. TOTAL CLASS T AMOUNT</b> \$	

## STATEMENT OF UNDERSTANDING

I understand that this allotment is legal and that by voluntarily completing this form, I am responsible for:

- **Ensuring** that the information is correct;
- **Reviewing** my Leave and Earnings Statement to ensure the allotment stops, starts, or changes as directed including amount and payee;
- **Collecting** overpayments from the receiver (payee) of the allotment, if I do not change or stop the allotment after a loan is repaid;
- **Contacting** the receiver (payee) of the allotment, at my expense, to obtain monthly statements for my personal records.

I also understand that any problems once the allotment is delivered to the receiver (payee) are beyond the control of the Defense Finance and Accounting Service (DFAS) and that DFAS is only responsible for ensuring proper delivery of any voluntary allotment for the period directed. I further understand that pursuant to conditions listed in the DoD 7000.14-R, Volume 7A, changes can be made by DFAS to an allottee's name, address, or account number.

<b>21. SIGNATURE OF ALLOTTER</b>	<b>22. DATE</b> ( <i>YYYYMMDD</i> )
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**NOTE 1.** Must be different address than allotter. Each dependent allotment must have a different credit line. Only one support allotment per dependent is allowed.

**NOTE 2.** This is a voluntary allotment and can be to any payee you desire.

**AMERICAN EQUITY INVESTMENT LIFE INSURANCE COMPANY  
ENROLLMENT FOR GROUP LIFE INSURANCE  
NATIONAL GUARD ASSOCIATIONS OF LOUISIANA**

Policy Number \_\_\_\_\_ Effective Date \_\_\_\_\_ Unit Code No. \_\_\_\_\_

I am now an active member of The National Guard. I hereby make application for life insurance for which I am eligible under the Group Insurance Contract issued to National Guard Associations of Louisiana, by the American Equity Investment Life Insurance Company of Des Moines, Iowa. The following statements and answers are true and correct to the best of my knowledge and belief.

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Middle

MAILING ADDRESS \_\_\_\_\_  
No. (RFD) City State Zip

BENEFICIARY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NATIONAL GUARD UNIT \_\_\_\_\_ HOME TELEPHONE \_\_\_\_\_

MEMBER'S DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ DATE OF ENLISTMENT \_\_\_\_\_  
Mo./Day/Year State Mo./Day/Year

1. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. ☐ Married ☐ Single
2. Do you or your dependents know of any impairments now existing in you health or physical condition? ☐ Yes ☐ No
3. Have you or your dependents had any illness or injuries during the past 3 years? ☐ Yes ☐ No
4. Have you or your dependents ever had any of the following: Tuberculosis, Rheumatism, Disease of Heart, Lungs, Stomach, Kidney, Liver, Brain or any other disease or illness? ☐ Yes ☐ No
5. Have you or your dependents been absent from your regular duties due to illness or injury during the past six months? ☐ Yes ☐ No
6. Have you ever been refused, postponed or rated-up by a life insurance company? ☐ Yes ☐ No  
If so, give name of company, date and cause \_\_\_\_\_

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, INDICATE BELOW THE NATURE OF THE ILLNESS OR INJURY, DURATION, SEVERITY, WITH DATES AND DETAILS AND THE NAME OF PHYSICIAN.

THIS APPLICATION IS REQUESTED FOR: <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> INCREASE		
GUARD MEMBER:	DEPENDENT	SPOUSE
2. <input type="checkbox"/> \$10,000 (\$3.66)	2. <input type="checkbox"/> \$2,000 (\$1.33)	1. <input type="checkbox"/> \$5,000 (\$2.00)
4. <input type="checkbox"/> \$20,000 (\$7.00)	3. <input type="checkbox"/> \$5,000 (\$3.33)	2. <input type="checkbox"/> \$10,000 (\$3.66)
5. <input type="checkbox"/> \$25,000 (\$8.67)	4. <input type="checkbox"/> \$10,000 (\$6.66)	5. <input type="checkbox"/> \$25,000 (\$8.67)
6. <input type="checkbox"/> \$30,000 (\$10.34)		
8. <input type="checkbox"/> \$40,000 (\$13.67)		
A. <input type="checkbox"/> \$50,000 (\$17.00)		

**COMPLETE FOR DEPENDENT OR SPOUSE COVERAGE**

Spouse: \_\_\_\_\_ Spouse DOB: \_\_\_\_\_  
Last First Middle Mo./Day/Year

Number of Children Under Age 21: \_\_\_\_\_ DOB of Oldest Child Under Age 21: \_\_\_\_\_  
Mo./Day/Year

**ACKNOWLEDGEMENT AND AUTHORIZATION:** I hereby authorize any physician, hospital, clinic, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or of any member of my family or my (our) health to give this requested information to the American Equity Investment Life Insurance Company (or its reinsurers). A photographic copy of this authorization shall be as valid as the original. I hereby assign any experience premium refunds to The National Guard Associations of Louisiana to be used for purposes which benefit the policies and programs of the National Guard Associations of Louisiana. I acknowledge receipt of form 5609, "Your Insurance Application and How it is Handled". Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated in \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_  
City, State

\_\_\_\_\_  
Signature of Witness Signature of Member

NG-ENRL-LA

02/2001

# LOUISIANA NATIONAL GUARD ENLISTED ASSOCIATION

LANGEA MEMBERSHIP APPLICATION

DATE: \_\_\_\_\_

Please print and fill in the appropriate information, then mail it to: LANGEA, 100 Richland Drive West, Mandeville, LA 70448.

☐ Yes, I want to join LANGEA/EANGUS and take advantage of the great benefits, and I want to be a member of the TWO organizations that is fighting to protect the benefits of all enlisted members of the National Guard.

Name: \_\_\_\_\_ Grade/Rank: \_\_\_\_\_  
(LAST) (FIRST) (MI)

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP Code: \_\_\_\_\_

Telephone Number: H (\_\_\_\_\_) \_\_\_\_\_ W (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Spouse Names: \_\_\_\_\_ Refereed by: \_\_\_\_\_

Branch of Service: Army ☐ Air ☐ Unit: \_\_\_\_\_ Location: \_\_\_\_\_

Membership Category: AGR ☐ TECH ☐ M-DAY ☐ RETIRED ☐

Membership Type: ANNUAL ☐ LIFE ☐ ASSOCIATE ☐

I understand that, with acceptance of my application, \$1,000 AD&D Insurance (EANGUS) and such other benefits as may become effective during my membership will cover me.

☐ One Year - \$18.00 ☐ Allotment for payment of dues under the insurance program, complete this form and allotment form (blocks 1-6 and signature and date) and an insurance form, along with a one time check/cash for \$9.00, and mail to above address. ☐ Lifetime Membership as IAW dues on this page. The amounts LANGEA/EANGUS will be added together for cost at that age pay that amount. Example: If you are age 30 yrs old and join as a lifetime member for LANGEA, you pay: \$270.00 (plus \$10.00 Administration Fee) for a total of \$280.00; if you join both LANGEA & EANGUS, you pay: LANGEA \$270.00. EANGUS \$280.00, (PLUS A \$10.00 Administration Fee) for a total of \$560.00. Please makes your check payable to: LANGEA

Signature: \_\_\_\_\_

LANGEA EANGUS AGE AMT	LANGEA EANGUS AGE AMT	LANGEA EANGUS AGE AMT	LANGEA EANGUS AGE AMT	LANGEA EANGUS AGE AMT
18 \$378/\$388	27 \$297/\$307	36 \$216/\$226	45 \$135/\$145	54 \$54/\$100
19 \$369/\$379	28 \$288/\$298	37 \$207/\$217	46 \$126/\$136	55 \$45/\$100
20 \$360/\$370	29 \$279/\$289	38 \$198/\$208	47 \$117/\$127	56 \$36/\$100
21 \$351/\$361	30 \$270/\$280	39 \$189/\$199	48 \$108/\$118	57 \$27/\$100
22 \$342/\$352	31 \$261/\$271	40 \$180/\$190	49 \$99/\$109	58 \$18/\$100
23 \$333/\$343	32 \$252/\$262	41 \$171/\$181	50 \$90/\$100	59 \$9/\$100
24 \$324/\$334	33 \$243/\$253	42 \$162/\$172	51 \$81/\$100	60 00/\$100
25 \$315/\$325	34 \$234/\$244	43 \$153/\$163	52 \$72/\$100	
26 \$306/\$316	35 \$225/\$235	44 \$ 144/\$154	53 \$63/\$100	

LANGEA /EANGUS Membership Dues is a Anniversary Year {Example 1 April through 31 March}

## LANGEA MEMBERSHIP RECEIPT

To: \_\_\_\_\_

Date: From \_\_\_\_\_ To \_\_\_\_\_ Membership Year: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

LANGEA Signature

LANGEA Membership Fm1 Dated 31 October 2005

**ALL OTHER FORMS ARE OBSOLETE**